Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Chiropractic Services for Children

Billing Instructions

June 2000

Current Procedure Terminology CPT

About this publication

This publication supersedes all previous MAA Chiropractic Billing Instructions and Numbered Memorandum 99-15 MAA.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
June 2000

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

Table of Contents

Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.

Applying for a provider

Call:
Provider Enrollment Unit
(800) 562-6188 and
Select Option #1

or call one of the following numbers:

(360) 725-1033
(360) 725-1026
(360) 725-1032

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9249
Olympia WA 98507-9247

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

Or write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Who do I contact if I have questions regarding…

Payments, denials, general questions regarding claims processing, or Healthy Options?

Call:
Provider Relations Unit (PRU)
(800) 562-6188

Private insurance or third party liability, other than Healthy Options?

Write/call:
Division of Client Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
(800) 562-6136

Electronic Billing?

Write/call:
Electronic Billing Unit
PO Box 45511
Olympia, WA 98504-5511
(360) 725-1267

Definitions

This section defines terms and acronyms used throughout these billing instructions.

Children's Health Insurance Program (CHIP) - The Children's Health program is the state-funded program for children under age 18 who are not eligible for Medicaid. (*Not to be confused with the Children's Health Insurance Program – CHIP.)*

Chiropractic Care – Manipulation of the spine to facilitate the recuperative powers of the body and the relationship between the musculoskeletal structures and functions of the body to restore health.

Community Services Office(s) (CSO) - An office of the department [that] administers social and health services at the community level. (WAC 388-500-0005)

Core Provider Agreement - A basic contract that the Medical Assistance Administration (MAA) holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Department - The state Department of Social and Health Services. (WAC 388-500-0005)

Early and Periodic Screening, Diagnosis, And Treatment (EPSDT) – Also known as the "healthy kids" program, a program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid or the children's health program. (WAC 388-500-0005)

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medical Benefits (EOMB) – A federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

Facility setting maximum allowable fees – Fees paid when the provider performs the services in a facility setting and the cost of the resources are the responsibility of the facility (i.e. outpatient hospital).

General Assistance Unemployable (GA-U) – A state-funded program providing medical care to unemployable persons not eligible for or not receiving federal aid.

Healthy Kids (EPSDT) – See Early and Periodic Screening, Diagnosis, And Treatment (EPSDT).

Limited Casualty-Medically Needy Program (LCP-MNP) – A federally-funded program with a limited scope of medical coverage intended for persons whose income or resources exceed Medicaid's Categorically Needy Program (CNP) eligibility limits. The client's MAID card will show LCP-MNP in the program and scope of care area.

Managed Care – A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

Maximum Allowable - The maximum dollar amount a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320. (WAC 388-500-0005)

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Non-Facility Setting Maximum Allowable Fee – Fee paid for services when the provider performing the service typically bears the cost of resources, such as labor, medical supplies, and medical equipment associated with the service performed (i.e. office or clinic).

Patient Identification Code (PIC) - An alphanumeric code assigned to each Medical Assistance client consisting of:

a) First and middle initials (a dash (-) must be used if the middle initial is not indicated).
b) Six-digit birth date, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha character (tie breaker).

Program Support, Division of (DPS) - The division within the Medical Assistance Administration responsible for providing administrative services for the following: Claims Processing, Family Services, Managed Care Contracts, Provider Relations, Field Services, and Regulatory Improvement.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Remittance and Status Report (RA) - A report produced by the Medicaid Management Information System (MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. (42 CFR 433.136)

Title XIX - The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

Title XXI - The portion of the federal Social Security Act that authorizes grants to states for the Children's Health Insurance Program (CHIP).

Usual & Customary Fee – The rate that may be billed to the department for a certain service or equipment. This rate *may not exceed*:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

About the Program

What is the purpose of the Chiropractic Services for Children Program?

The purpose of the Medical Assistance Administration's (MAA's) Chiropractic Services for Children Program is to provide medically necessary chiropractic services to eligible MAA clients under 21 years of age.

Who is eligible to be reimbursed for chiropractic services?

MAA will pay only for chiropractic services that are:

- Provided by a chiropractor licensed in the state where services are provided and enrolled as an MAA provider;
- Within the scope of the chiropractor's license;
- Listed in this document (see *Coverage* section); and
- Medically necessary.

Client Eligibility

Who is eligible?

To be eligible for chiropractic services, clients must:

- Be under 21 years of age;
- Referred by a screening provider under the Healthy Kids/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program; and
- Present their Medical Assistance IDentification (MAID) card with one of the following identifiers:

MAID Identifier	Medical Program
CNP	Categorically Needy Program
CNP - CHIP	Categorically Needy Program – Children's Health Insurance Program
CNP - Children's Health	Categorically Needy Program – Children's Health
GA-U - No Out of State Care	General Assistance-Unemployable - No Out of State Care
General Assistance - No Out of State Care	ADATSA
LCP - MNP	Limited Casualty Program - Medically Needy Program

☞ **Note:** Include the referring provider number in field 17a on the HCFA 1500 claim form. If no MAA provider number is available, enter the name in field 17. Keep referral information in the client's file.

Are children enrolled in managed care eligible for chiropractic services?

Clients with an identifier in the HMO column on their MAID cards are enrolled in one of MAA's Healthy Options managed care plans. All chiropractic services must be requested and provided directly through the client's Primary Care Provider (PCP). Clients can contact their PCP by calling the telephone number listed on their MAID card.

Please check the client's MAID card prior to scheduling services and at the time of service to make sure proper authorization or referral is obtained from the PCP and/or plan. You must bill the Healthy Options Plan directly for reimbursement for the chiropractic services.

Coverage

What is covered?

The Medical Assistance Administration (MAA) will pay only for the following:

- Unlimited chiropractic manipulative treatments of the spine; and
- X-rays of the spine limited to:
  - ✓ A single view when the treatment area can be isolated; and
  - ✓ The cervical, thoracic, and lumbo-sacral (anterior-posterior and lateral) areas of the spine when treatment cannot be isolated.

☞ **Note:** MAA does not reimburse for the following items under the Chiropractic Services for Children program:

- Therapy modalities such as light, heat, hydro, and physical;
- Any food supplements, medications, or drugs; and
- Any braces, cervical collars, or supplies.

Fee Schedule

The following chiropractic services are allowed only for clients under 21 years of age with a referral from an EPSDT provider. These rates are effective for dates of service on and after July 1, 2002.

Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT® procedure code descriptions.
To view the entire description, please refer to your current CPT book.

Procedure Code	Modifier	Brief Description	July 1, 2002 Maximum Allowable Fee
		Visits	
98940		Chiropractic manipulation	$16.15
98941		Chiropractic manipulation	22.07
98942		Chiropractic manipulation	28.67
		X-Rays	
72020		X-ray exam of spine	14.11
72020	26		4.78
72020	TC		9.33
72040		X-ray exam of neck spine	20.70
72040	26		7.05
72040	TC		13.65

Procedure Code	Modifier	Brief Description	July 1, 2002 Maximum Allowable Fee
72070		X-ray exam of thoracic spine	$21.84
72070	26		7.05
72070	TC		14.79
72100		X-ray exam of lower spine	22.07
72100	26		7.05
72100	TC		15.02

Modifiers

- **Professional Component only (modifier 26)** – This modifier identifies the x-ray professional component only. When the professional component (reading and interpretation of the x-ray) is performed separately, the service must be billed along with modifier 26.

- **Technical Component only (modifier TC)** – This modifier identifies the x-ray technical component only. When the technical component (taking of the x-ray) is performed separately, the service must be billed along with modifier TC.

- **Consultation only (modifier 1R)** – This modifier identifies the consultation on x-ray examination only. Pays at the professional component rate.

Billing

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

☞ **Note:** If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date of recoupment by the plan.

- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

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[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time period does not apply to overpayments that the provider must refund to DSHS. After the allotted time period, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA *Remittance and Status Report* for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;

- Attach the insurance carrier's statement or EOB;

- If rebilling, also attach a copy of the MAA *Remittance and Status Report* showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain their service via the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's MAID card to identify the client's PCCM.

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager (PCCM) name in field 17 on the HCFA-1500 claim form; and

- Enter the seven-digit identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

  Newborns of Healthy Options clients that are connected with a PCCM are fee-for-service until they have chosen a PCCM. All services should be billed to MAA.

☞ **Note:** If you treat a Healthy Options client that has chosen to obtain care with a PCCM and you are not the PCP, or the client was not referred to you by the PCCM/PCP, you may not receive payment. You will need to contact the PCP to get a referral.

What records must be kept?

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

Field Description/Instructions for Completion

1a. **Insured's I.D. No.**: Required. Enter the MAA Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each MAA client - exactly as shown on the client's Medical Assistance IDentification (MAID) card. The PIC consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available)
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY)
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d) An alpha or numeric character (tie breaker)

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same – then the word *Same* may be entered.

5 **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: When applicable, show the last name, first name, and middle initial of the insured if it is *different from* the name shown in *field 4*. Otherwise, enter the word *Same*.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, HO or Healthy Options First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payer of last resort.

11a. **Insured's Date of Birth**: When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Indicate *yes* or *no*. If yes, you should have completed *fields 9a. - d.*

17. **Name of Referring Physician or Other Source**: Enter the EPSDT/Healthy Kids referring physician. This field *must* be completed.

17a. **I.D. Number of Referring Physician**: Enter the seven-digit, MAA-assigned identification number of the EPSDT/Healthy Kids provider who *referred* the service.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., June 4, 2000 = 070400).

24B. **Place of Service**: Required. These are the only appropriate code(s) for MAA's Chiropractic Services for Children program:

Code	To Be Used For
3	Office

24C. **Type of Service**: Required. Enter a **9** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate procedure code for the services being billed. **Modifier**: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM, or relate each line item to *field 21* by entering a 1, 2, 3, or 4.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not include sales tax. Sales tax is automatically calculated by the system and included in your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units for each line. These figures must be whole units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: This is any nine-digit alphanumeric entry ***that you may use as your internal reference number***. *You* create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N.:

This is the seven-digit number assigned to you by MAA for:

A. An individual practitioner (solo practice); **or**
B. An identification number for individuals only when they are part of a group practice (see below).

Group:

This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.

NOTE: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

Sample HCFA-1500 Claim Form